| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 15E594 | A. BUILDING _____ B. WING _____ | 03/18/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| MCGIVNEY HEALTH CARE CENTER | 2907 EAST 136TH STREET CARMEL, IN46033 |

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| F0000 | This visit was for a Recertification and State Licensure Survey<br><br>Survey dates: March 14th, 15th, 16th, 17th, and 18th, 2011<br><br>Facility Number: 000545<br>Provider Number: 15E594<br>AIM Number: 100267350<br><br>Survey Team:<br>Michelle Hosteter RN--Team Coordinator<br>Janet Stanton, RN<br>Rita Mullen, RN<br><br>Census bed type:<br>NF--27<br>Total--27<br><br>Census Payor Type:<br>Medicaid--26<br>Other--1<br>Total--27<br><br>Sample: 10<br><br>These deficiencies also reflect state findings in accordance with 410 IAC 16.2.<br><br>Quality review completed 3-24-11<br>Cathy Emswiller RN | F0000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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| F0157 SS=D | Based on record review and interview, the facility failed to notify the physician of projectile vomiting in a timely manor for a resident with a gastric feeding tube. This impacted 1 of 1 resident with a gastric feeding tube in a sample of 10. (Resident #15)<br><br>Findings include:<br><br>The clinical record of Resident #15 was reviewed on 3/15/11 at 12:35 P.M.<br><br>Diagnoses for Resident #15 included, but were not limited to, dysphasia, cerebral vascular accident, and chronic obstructive pulmonary disease.<br><br>A "Guidelines for Physician Notification for Change in Contrition Overview", not dated, received from the facility administrator on 3/18/11, indicated the following:<br><br>"I. Prompt notification for acute problems - These situation require direct communication with the physician and may not be faxed. The following symptoms, signs and laboratory values should prompt the nurse to notify the physician as soon as possible, either directly or by beeper. If you do not obtain a response from the physician, call the | F0157 | Disclaimer: Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. 1. It is the policy of McGivney Health Care Center to immediately notify the resident's physician of any changes in resident's conditions. Nurses were immediately in-serviced on Physician Notification of Changes Condition. Resident # 15 clinical record reviewed and a new order obtained to clarify current g-tube order to read check residual every shift and PRN. If residual is greater than 150ccs withhold tube feeding and notify physician. Resident # 15 care plan was updated to read: after episodes of nausea and vomiting nurse to assess amount of residual, lung sounds, bowel sounds, and abdominal distention and documented in the clinical record with date and time. 2. An audit of the residents revealed that no other residents were affected by this practice. 3. Nursing in-services conducted on: Physician Notification of Changes Condition The | 04/17/2011 |

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| | designated alternate physician. If you still do not receive a response, notify the Medical Director for further instructions....<br><br>A. Symptoms Warranting Prompt Notification<br>1. Any complaint or apparent discomfort which is:<br>a. Sudden in onset...<br>2. Specific examples of new onset symptoms...vomiting > 2 times in 24 hrs...."<br><br>A nursing note, dated 1/6/2011 at 6:30 A.M., indicated"... Projectile vomiting at 2 AM (sic). G-tube feeding held for 2 hrs. Then restarted. No more vomiting [after] 4 AM (sic)...."<br><br>A nursing note, dated 1/6/11 at 10:00 A.M., indicated "...Pegtube patent, placement verified, [no] difficulty [with] flushes, [no] residual noted. Infusing Osmolite 1.5 @ 85 cc (cubic centimeters)/hr via gravity...."<br><br>A nursing note, dated 1/6/11 at 11:00 A.M., indicated "Feeding held for 2 hours d/t (due to) emesis. HOB (head of bed) [up]...."<br><br>A nursing note, dated 1/6/11 at 1:00 P.M., | | facility's Guidelines for Physician Notification for Changes in Condition Administration of Enternal Feedings 24hr Report Log Documentation 4. Charge nurses are responsible for notifying the resident's physicians of any change of condition. All nurses will be responsible for documenting on the 24hr Report Log change of condition on residents. The DON/designee is responsible for ongoing monitoring of 24hour Report Log. Nurses failing to adhere to the facility policies and procedures will be counseled by the DON up to and including disciplinary action. DON will bring findings from 24hour Report Log to QA weekly. | |

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| | indicted "Pegtube infusing [without] c/o (complaint of) further emesis at this time. HOB [up]..."<br><br>A nursing note, dated 1/6/11 (not time noted), indicted "...Spoke [with] (name of hospital)...about medical records on a recent Modified Barium Swallow (MBS). Calls returned [with] [no] records available as such. MD notified [with] new order received. Appt (appointment) made for MBS.... Son...made aware..." The tube feeding was held twice, for 2 hours due to vomiting, but the physician was not contacted until some time after 1:00 P.M.<br><br>During a interview with the Director of Nursing, on 3/16/11 at 9:30 A.M., she indicated the physician was called on 3/6/11 in regard to the MBS and he would have been told at that time about the vomiting. This was at least two hours after the tube feed was held the second time due to vomiting.<br><br>3.1-5(a)(2) | | | |

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| F0272 SS=D | Based on record review and interview, the facility failed to assess a resident with a gastric feeding tube, after vomiting, for bowel sounds, abdominal distention or lung sounds. This impacted 1 of 1 residents reviewed for feeding tubes in a sample of 10. (Resident #15) The facility also failed to assess a resident at high risk for skin breakdown. This impacted 1 of 4 reviewed for pressure in a sample of 10. (Resident#21)<br><br>Findings include:<br><br>1. The clinical record of Resident #15 was reviewed on 3/15/11 at 12:35 P.M.<br><br>Diagnoses for Resident #15 included, but were not limited to, dysphasia, cerebral vascular accident [stroke], and chronic obstructive pulmonary disease.<br><br>A Nursing Procedure titled "Naso-Gastric Tube Feedings (not dated) received from the facility administrator, on 3/18/11, indicated the following:<br><br>"...Procedure<br><br>...Check abdomen for distention before feeding. If distended, listen for bowel sounds throughout lower abdomen. Do not give feeding if resident indicates any | F0272 | Disclaimer: Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. 1. It is the policy of McGivney Health Care Center to conduct initial and periodic assessments of each resident's functional capability. Resident # 15 clinical record reviewed and a new order obtained to clarify current g-tube order to read check residual every shift and PRN. If residual is greater than 150ccs withhold tube feeding and notify physician. Resident # 15 care plan was updated to read: after episodes of nausea and vomiting nurse to assess amount of residual, lung sounds, bowel sounds, and abdominal distention and documented in the clinical record with date and time. Resident #21 area on her spine was assessed, measured and documented by nursing staff in clinical record on the day it was observed. Resident #21's care plan was updated to reflect current interventions. 2. Audits of the residents revealed that no other residents were affected by | 04/17/2011 |

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| | distress or retention. Residual or retention can lead to regurgitation or aspiration.<br><br>...9. Watch the resident closely for signs of aspiration, choking, cyanosis, or regurgitation..."<br><br>The Medication Administration Record, dated for January 2011, indicated the feeding tube residual amount and placement was checked on 1/6/11 at 6:00 A.M., 2:00 P.M. and 10:00 P.M.<br><br>A nursing note, dated 1/6/2011 at 6:30 A.M., indicated "...Projectile vomiting at 2 AM (sic). G-tube feeding held for 2 hrs. Then restarted. No more vomiting [after] 4 AM (sic)...BP (blood pressure 130/72." The resident was not assessed for bowel sounds, abdominal distention or lung sounds after vomiting.<br><br>A nursing note, dated 1/6/11 at 10:00 A.M., indicated "...Pegtube patent, placement verified, [no] difficulty [with] flushes, [no] residual noted. Infusing Osmolite 1.5 @ 85 cc (cubic centimeters)/hr via gravity...."<br><br>A nursing note, dated 1/6/11 at 11:00 A.M., indicated "Feeding held for 2 hours d/t (due to) emesis. HOB (head of bed) [up]...." The resident was not assessed for | | this practice. 3. Nursing in-service conducted on: Comprehensive Assessments and Detailed Follow-up Administration of Enternal Feedings 24hr Report Log Documentation 4. All nurses will be responsible for documenting on the 24hr Report Log any residents with G-tubes that have episodes of nausea and vomiting. All nurses will be responsible for documenting on the 24hr Report Log the staging, measurements and physician notification of pressure sores. The DON/designee is responsible for ongoing monitoring of 24hour Report Log. Nurses failing to adhere to the facility policies and procedures will be counseled by the DON up to and including disciplinary action. DON will bring findings from 24hour Report Log to QA weekly. | |

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| | bowel sounds, abdominal distention or lung sounds after vomiting.<br><br>A nursing note, dated 1/6/11 at 1:00 P.M., indicted "Pegtube infusing [without] c/o (complaint of) further emesis at this time. HOB [up]..."<br><br>During an interview with the Director of Nursing, on 3/16/11 at 9:30 A.M., she indicated she had talked to the nurse, that worked that night, and that the Resident's lungs were listened to after vomiting, She did not indicated that the abdomen was assessed for bowel sounds or distention. | | | |

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| F0272 SS=D | 2. In an interview during the initial orientation tour on 3/14/11 at 11:30 A.M., Director of Nursing #4 indicated Resident #21 used a geri-chair for mobility, was receiving Hospice services, had skin tears on one leg, and had a Stage I pressure area of the mid-spine area of her back. The nurse indicated an order for a "Duoderm" covering treatment had recently been obtained.<br><br>On 3/14/11 at 11:30 A.M., the resident was observed in bed, laying on her back. Director of Nursing #4 indicated the resident's mattress was the facility's standard "pressure-reducing" mattress--one that had a foam insert for the area of the body. The resident's geri-chair was observed at that time to have no pressure-relieving cushions on the seat or at the back.<br><br>The clinical record for Resident #21 was reviewed on 3/15/11 at 9:15 A.M. Diagnoses included, but were not limited to, dementia, C.V.A. [cerebral vascular accident--"stroke"] with right hemiparesis [paralysis], anemia, hypertension, chronic pain, and history of weight loss.<br><br>A nurse's "Condition Change Form" progress note, dated 3/6/11, indicated "Area to bony prominence of spine." | F0272 | Disclaimer: Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. 1. It is the policy of McGivney Health Care Center to conduct initial and periodic assessments of each resident's functional capability. Resident # 15 clinical record reviewed and a new order obtained to clarify current g-tube order to read check residual every shift and PRN. If residual is greater than 150ccs withhold tube feeding and notify physician. Resident # 15 care plan was updated to read: after episodes of nausea and vomiting nurse to assess amount of residual, lung sounds, bowel sounds, and abdominal distention and documented in the clinical record with date and time. Resident #21 area on her spine was assessed, measured and documented by nursing staff in clinical record on the day it was observed. Resident #21's care plan was updated to reflect current interventions. 2. Audits of the residents revealed that no other residents were affected by | 04/17/2011 |

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| | There were no previous nurse's progress notes with assessment documentation of the resident's mid-spine area. On 3/6/11, an order was obtained from the attending physician for "Duoderm to bony prominence of spine. Change every 3 days."<br><br>A "Braden Scale for Predicting Pressure Sore Risk" form had entries for 2/27 and 3/1/11. The resident scored a "12" on 2/27, and a "9" on 3/1/11. The assessment key indicated a score between 10-12 was "High Risk," with a score of 9 or below "Very High Risk." A "Second Assessment" note, dated 3/1/11 indicated "Resident has no open or red areas. Pressure reducing mattress to bed and wheelchair. Turned every 1-2 hours. Heels floated while in bed for no pressure. Is receiving Hospice services."<br><br>A care plan entry, dated 2/11/11, addressed a problem of "At risk for skin breakdown." The interventions included, but were not limited to, the following: "Monitor skin every shift for signs/symptoms of potential skin breakdown; .... Braden's scale quarterly and P.R.N."<br><br>On 3/18/11 at 10:30 A.M., the resident was observed in bed for a dressing change | | this practice. 3. Nursing in-service conducted on: Comprehensive Assessments and Detailed Follow-up Administration of Enternal Feedings 24hr Report Log Documentation 4. All nurses will be responsible for documenting on the 24hr Report Log any residents with G-tubes that have episodes of nausea and vomiting. All nurses will be responsible for documenting on the 24hr Report Log the staging, measurements and physician notification of pressure sores. The DON/designee is responsible for ongoing monitoring of 24hour Report Log. Nurses failing to adhere to the facility policies and procedures will be counseled by the DON up to and including disciplinary action. DON will bring findings from 24hour Report Log to QA weekly. | |

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| | by R.N. #3, with the facility consultant Wound Nurse in attendance. Initially, R.N. #3 identified an area at the resident's coccyx, which had a 0.3 cm. [centimeter] wedge-shaped skin tear, surrounded by 6 cm. bright red area. The coccyx had a roughened texture. The nurse used a gloved finger to slightly lift the skin tear, and commented "It's dry." When requested to view the mid-spine area, the nurse said "Oh, yeah," and lifted the resident's shirt up. The resident was observed to have a mile kyphosis [curvature of the spine]. The area was covered with a Duoderm dressing, which the nurse removed. A 5 cm. oblong-shaped reddened area was observed over the bony prominence's of the resident's mid-spine area, with a 2 cm. darker circle in the center of the area. The skin was not open.<br><br>During a daily conference on 3/18/11 at 11:00 A.M., the Administrator and Director of Nurses were given the opportunity to provide any assessment documentation previously completed related to the resident's coccyx and mid-spine areas.<br><br>On 3/18/11 at 1:45 P.M., R.N. #6 provided copies of the consultant Wound Nurse's "Wound Progress | | | |

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| | Note/Reassessment" documentation. The last form was dated 3/11/11 and addressed the resident's right shin skin tear. She indicated assessments of the resident's coccyx and mid-spine areas, completed by the facility nursing staff, were not found.<br><br>On 3/18/11 at 2:15 P.M., R.N. #6 indicated the resident had a kyphosis of her spine, and had been off of her back for at least 30 minutes. The areas on the coccyx and mid-back were now blanchable and no longer reddened. The resident's coccyx and mid-spine area were observed to be only slightly pink in color. A low-air loss specialty mattress had been placed on the bed. R.N. #6 indicated the facility was obtaining a pressure-relieving cushion to be positioned at the resident's back when she was up in the geri-chair.<br><br>3.1-31(c)(2)<br>3.1-31(c)(6) | | | |

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| F0314 SS=D | Based on observation, interview, and record review, the facility failed to provide pressure relieving devices in a timely manner for 1 of 4 residents who had pressure sores and/or potential open area skin issues, in a sample of 10 residents reviewed. [Resident #21]<br><br>Findings include:<br><br>In an interview during the initial orientation tour on 3/14/11 at 11:30 A.M., Director of Nursing #4 indicated Resident #21 used a geri-chair for mobility, was receiving Hospice services, had skin tears on one leg, and had a Stage I pressure area of the mid-spine area of her back. The nurse indicated an order for a "Duoderm" covering treatment had recently been obtained.<br><br>The American Medical Directors Association's "Pressure Ulcers in the Long-Term Care Setting, Clinical Practice Guideline" manual, copywrite 2008, defines a "Stage I" pressure area as "Intact skin with non-blanchable redness of a localized area, usually over a bony prominence.... The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue.... May indicated "at risk" persons (heralding sign of risk)." | F0314 | Disclaimer: Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. 1. It is the policy of McGivney Health Care Center to provide pressure relieving devices in a timely manor to prevent pressure sores. Resident # 21 did receive a cushion for her back and a low air mattress before the survey team exited. Resident #21 area on her spine was assessed and measured and documented by nursing staff in clinical record. Resident #21's care plan was update to reflect current interventions. 2. An audit of the residents revealed that no other residents were affected by this practice. 3. Nursing in-service conducted on: Immediate Treatments to Prevent/Heal Pressure Sores and Detailed Follow-up The facility's new Policy and Procedure for Braden Scale, Skin Assessments and Providing Pressure Relieving Devices in a Timely Manor 24hr Report Log Documentation 4. All nurses will be responsible for documenting on the 24hr Report | 04/17/2011 |

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| | 15E594 | A. BUILDING _____ B. WING _____ | 03/18/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| MCGIVNEY HEALTH CARE CENTER | 2907 EAST 136TH STREET CARMEL, IN46033 |

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| | On 3/14/11 at 11:30 A.M., the resident was observed in bed, laying on her back. Director of Nursing #4 indicated the resident's mattress was the facility's standard "pressure-reducing" mattress--one that had a foam insert for the area of the body. She indicated she had contacted the Hospice agency the previous Friday to request a specialty pressure-relieving mattress or over-lay, and was told the agency did not provided a low-air loss mattress unless a resident already had a Stage III pressure sore.<br><br>The resident's geri-chair was observed at that time to have no pressure-relieving cushions on the seat or at the back.<br><br>On 3/16/11 at 10:35 A.M., the resident was observed in the main dining room/activity room. She was wheeled into the area by the beautician, and placed at a table in front of the T.V. The resident was sitting on a cushion in the seat of the geri-chair, but had no cushion or other pressure-relieving device for her back and spine.<br><br>On 3/17/11 at 9:30 A.M., the resident was observed in the main dining room. There was a pressure-relieving cushion on the seat of the geri-chair, but no pressure-relieving device behind her back. | | Log any new pressure sores, the interventions that were implemented. The DON/designee is responsible for ongoing monitoring of 24hour Report Log. Nurses failing to adhere to the facility policies and procedures will be counseled by the DON up to and including disciplinary action. DON will bring findings from 24hour Report Log to QA weekly. | |

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| | The resident's bed was observed to have the same standard "pressure-reducing" foam insert mattress.<br><br>On 3/18/11 at 10:30 A.M., the resident was observed in bed for a dressing change by R.N. #3, with the facility consultant Wound Nurse in attendance. Initially, R.N. #3 identified an area at the resident's coccyx, which had a 0.3 cm. [centimeter] wedge-shaped skin tear, surrounded by 6 cm. bright red area. The coccyx had a roughened texture. The nurse used a gloved finger to slightly lift the skin tear, and commented "It's dry." When requested to view the mid-spine area, the nurse said "Oh, yeah," and lifted the resident's shirt up. The resident was observed to have a mile kyphosis [curvature of the spine]. The area was covered with a Duoderm dressing, which the nurse removed. A 5 cm. oblong-shaped reddened area was observed over the bony prominence's of the resident's mid-spine area, with a 2 cm. darker circle in the center of the area. The skin was not open.<br><br>The resident was observed to be laying on the facility's standard pressure-reducing mattress. The geri-chair had the seat cushion, but no device for the back. The geri-chair was observed to have a stiff | | | |

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| | vinyl upholstery covering the hard cushion material underneath. In an interview at that time, Director of Nursing #5 indicated she would call the Hospice agency to see about obtaining a specialty mattress and a cushion for the resident's back. She reported later at 11:00 A.M. that the Hospice agency had criteria for determining when they would provide specialty mattresses or other pressure-relieving devices, but would supply a low-air loss mattress for the resident.<br><br>In an interview on 3/18/11 at 11:00 A.M., the Administrator indicated she had not known about the resident's skin areas. She indicated the facility did, in fact, have it's own low-air loss mattress which was not currently in use by any other resident, and that it would be placed on the resident's bed immediately.<br><br>On 3/18/11 at 2:15 P.M., R.N. #6 indicated the resident had a kyphosis of her spine, and had been off of her back for at least 30 minutes. The areas on the coccyx and mid-back were now blanchable and no longer reddened. The resident's coccyx and mid-spine area were observed to be only slightly pink in color. A low-air loss specialty mattress had been placed on the bed. R.N. #6 indicated the | | | |

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| | facility was obtaining a pressure-relieving cushion to be positioned at the resident's back when she was up in the geri-chair.<br><br>The clinical record for Resident #21 was reviewed on 3/15/11 at 9:15 A.M. Diagnoses included, but were not limited to, dementia, C.V.A. [cerebral vascular accident--"stroke"] with right hemiparesis [paralysis], anemia, hypertension, chronic pain, and history of weight loss.<br><br>The March, 2011 physician order recap [recapitulation] sheet listed an order, dated 9/25/09, for "Bacitracin/Nystatin/Zinc 1:1:1 --apply topically to buttocks/sacrum daily P.R.N. [as needed]."<br><br>A nurse's "Condition Change Form" progress note, dated 3/6/11, indicated "Area to bony prominence of spine." There were no previous nurse's progress notes with documentation of the resident's mid-spine area. On 3/6/11, an order was obtained from the attending physician for "Duoderm to bony prominence of spine. Change every 3 days."<br><br>An attending physician's order, dated 3/10/11, indicated "To have pressure relieving specialty mattress second to open area on spine. Hospice to provide." | | | |

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| | The resident was admitted to Hospice care on 2/15/11.<br><br>A "Braden Scale for Predicting Pressure Sore Risk" form had entries for 2/27 and 3/1/11. The resident scored a "12" on 2/27, and a "9" on 3/1/11. The assessment key indicated a score between 10-12 was "High Risk," with a score of 9 or below "Very High Risk." A "Second Assessment" note, dated 3/1/11 indicated "Resident has no open or red areas. Pressure reducing mattress to bed and wheelchair. Turned every 1-2 hours. Heels floated while in bed for no pressure. Is receiving Hospice services."<br><br>One care plan entry, dated 2/11/11, addressed a problem of "Incontinent of bowel and bladder...." One of the interventions was listed as "Monitor and record skin condition every shift for redness/discoloration/open areas. Alert charge nurse if observed for physician notification to obtain treatment orders as needed."<br><br>Another care plan entry, dated 2/11/11, addressed a problem of "At risk for skin breakdown." The interventions were listed as: "Monitor skin every shift for signs/symptoms of potential skin breakdown....; pressure reduction device: | | | |

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| | on bed when [resident's name] in bed and on chair when up; turn and reposition every 1-2 hours; keep skin clean/dry and bed linens clean, dry and wrinkle free every shift; offer fluids and encourage [resident] to consume; diet as ordered; do not position directly on trochanter when side-lying position used. Maintain head of bed at lowest degree of elevation possible; apply pillows to relieve pressure on heel(s) when in bed/chair; avoid exposure to hot water and use mild cleansing agent and gentle touch to minimize irritation and dryness of skin, use positional devices (e.g. pillows, foam wedges) to keep bony prominence's from direct contact with one another; Braden's scale quarterly and P.R.N." Another entry, not dated, was added for "geri sleeves as needed."<br><br>3.1-40(a)(2) | | | |

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| F0372 SS=A | Based on observation and interview, the facility failed to ensure the facility dumpster could be closed in order to prevent potential spillage of trash, for 1 of 1 dumpster that served the facility.<br><br>Findings include:<br><br>On 3/14/11 at 10:00 A.M., the facility dumpster was observed positioned on the opposite side of the parking lot, at the front of the main building. The front sliding door was open, both rear sliding panel doors were open, and half of the hinged top cover was missing. Plastic bags of trash were observed stacked inside up to the top of the dumpster.<br><br>On 3/14/11 at 12:00 and 1:00 P.M., the dumpster was observed with the front sliding door and the two rear sliding panel doors in an open position. Half of the hinged top cover was missing.<br><br>On 3/15/11 at 8:45 and 11:15 A.M., the dumpster was observed with the front and rear doors closed, but half of the hinged top cover was still missing.<br><br>In an interview during the environmental tour on 3/15/11 at 1:00 P.M., the Maintenance Supervisor indicated the refuse company would have emptied the | F0372 | Disclaimer: Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. 1. The facility immediately contacted Republic dumpster service for a replacement dumpster which was delivered during the night within 24hrs. 2. The facility only has one dumpster. 3. Dumpster was put on the maintenance daily check sheet for the maintenance staff to be responsible for visually observing and ensuring the dumpster is in proper working order every business day. 4. Maintenance will be responsible for visually observing and ensuring the dumpster is in proper working order every business day. Maintenance will be responsible for documenting on their Maintenance Daily Check sheet. Maintenance will immediately notify Administrator of any problems with the operation of the dumpster. | 04/17/2011 |

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| | dumpster the previous Friday, and had probably broken the top then. In an interview at the same time, the Administrator indicated the facility had experience previous problems with the company that was contracted to empty the dumpster, and that she would call and have them replace the dumpster.<br><br>3.1-21(i)(5) | | | |
| F0458<br>SS=D | Based on observation, record review and interview, the facility failed to ensure bedrooms measured at least 80 square feet per resident, in 2 of 17 resident rooms.[ Rooms #1 and Room #5]<br><br>Findings include:<br><br>Following the entrance conference on 3/14/11 at 10:10 A.M., the Administrator provided a completed "Bed Inventory sheet" form. The form indicated resident room #1 was a NF/Title 19 certified bed and it had 2 resident beds; and Room #5 was also a NF/Title 19 certified bed and it had 3 resident beds.<br><br>During the environmental tour on 3/15/11 at 1 P.M., Room# 1 was observed to have 2 resident beds with a resident occupying | F0458 | F 458 Resident Rooms We are requesting a variance for the room size of room 1 and room 5 as they meet the needs of the residents and do not create a hazard to the safety of the residents. Please see the enclosed letter requesting a room waiver approval from Ms. Rhoades, Director of Long Term Care of ISDH. Gibault Care Inc. is responsible for the finding. | 04/17/2011 |

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| | each bed. Room #5 was observed to have 3 resident beds with only one currently occupied.<br><br>In an interview on 3/15/11 at 1 P.M., the Administrator indicated they had recently remodeled Room #1 and had paperwork prepared to send to Indiana State Department of Health [ISDH] to discontinue the room waiver. However, the paper had not yet been submitted to ISDH. The administrator also indicated they intended to remove one bed from Room #5, but had not done so yet.<br><br>The measurements for each room were as follows:<br><br>*Room #1- 149.67 square feet; 74.83 square feet per resident bed.<br><br>*Room #5-229.75 square feet; 76.58 square feet per resident bed.<br><br>3.1-19(l)(2) | | | |

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| F0514 SS=E | Based on record review and interview, the facility failed to ensure that 4 of 7 residents receiving psychoative medications, had consistent documentation of behaviors, P.R.N. psychoactive medications, and nonpharmocological interventions prior to the use of the P.R.N. psychoactive medication; in a survey sample of 10 residents.<br>[Resident #2, #33, #14 and #9]<br><br>Findings include:<br><br>1. On initial tour on 3/14/11 at 10:15 A.M., DON #4 indicated that Resident #2 had behaviors, was cognitively impaired, received psych meds and was not interviewable.<br><br>The clinical record for Resident #2 was reviewed on 3/16/11 at 10:45 A.M. Diagnoses included, but were not limited to: Dementia with delusional features, psychosis, anxiety, and depression.<br><br>The controlled substance record for Resident #2 for Ativan 0.5 mg P.R.N. indicated that resident had received medication on following dates:<br>12/14/10- 9:30 P.M.<br>12/29/10 -9 A.M. | F0514 | Disclaimer: Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. 1. It is the policy of McGivney Health Care Center to provide each resident with a complete, accurate, accessible organized clinical record. All nurses were in-serviced on the facility's Behavior Documentation and new Policy and Procedure for Behavior Documentation to ensure the clinical records for residents # 2, #9, #14, and #33 would project consistent documentation, and ensure that all nonpharmocological interventions were utilized prior to P.R.N.s. 2. An audit was conducted on all other resident's receiving P.R.N.s for behaviors were reviewed by QA and individual adjustments made as appropriate. 3. Nursing in-service conducted on: Behavior Documentation The facility's new Policy and Procedure for Behavior Documentation 24hr Report Log Documentation All Staff in-service conducted on: Behavior Documentation 4. | 04/17/2011 |

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| | 12/30/10- 12<br>1/5/11- 10A<br>1/7/11-5P<br>1/8/11-8:15A<br>1/12/11-9A<br>1/13/11-9A<br>1/21/11-9P<br>1/22/11-9:30A<br>1/23/11-9A<br>1/23/11- 1P<br>1/28/11- 1P<br>1/29/11-1:30 P<br>2/4/11- 8A<br>2/4/11- 6:30 P<br>2/5/11- 11P<br>2/6/11- 9A<br><br>Behavior logs were reviewed for December 2010, January 2011, February 2011, and March 2011. The behaviors being monitored were: Agitation, insomnia, yelling/cursing, and delusions.<br><br>The behavior log for December showed that the resident had episodes of agitation/yelling and cursing on 12/3/10 in the evening and 12/9/10 in the evening. There was nothing marked for behavior log marked insomnia, and the 12/1/10 was marked on days and nights regarding delusions"... (i.e.[example] thinking car is here +[and] can drive home)..." | | Charge nurses are responsible for consistently documenting all nonpharmocological interventions prior to using P.R.N.s. on the Behavior Monthly Flow Record, MAR and documenting any narratives on the Behavior Notes. All nurses will be responsible for documenting on the 24hr Report Log any utilization of P.R.N. psychoactive medications SSD/designee will be responsible for behavior audits each business day and bring findings to QA weekly. Nurses failing to adhere to the facility policies and procedures will be counseled by the DON up to and including disciplinary action. All other staff is required to document on the Behavior Monthly Flow Record and interventions they tried with resident and document any narratives on the Behavior Notes | |

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| | The M.A.R.[ medication administration record] for December 2010 indicated on 12/14/10 at 9:50 P.M. the resident received Ativan 0.5 mg P.O. [by mouth]every six hours as needed for anxiety, agitation .<br><br>The behavior log for January 2011 showed that the resident had one episode of agitation on 1/8/11. For yelling and cursing behavior: 1/5/11 for days, 1/9/11 for days and evenings, on 1/20/11 during nights, 1/22/11 during nights, 1/27/11 during nights and 1/30/11 during evenings she displayed this behavior. For delusional behavior the sheet was blank.<br><br>The M.A.R. for January 2011 indicated she received P.R.N. Ativan on 1/28/11, but no time was given.<br><br>The behavior log for February 2011 indicated the resident had agitation on 2/3/11 at night. The resident had insomnia at night on the following dates: 2/7, 2/10, 2/11, 2/14/2/15, 2/18, 2/27, and 2/28. The resident had yelling and cursing during the day on: 2/8/ and 2/15. For the evening on 2/13 and for nights 2/3 and 2/28.<br><br>The February 2011 M.A.R. indicated she received P.R.N. Ativan on 2/5/11 at 10 P.M. and 2/6/11 at 9 A.M. and 2/14 at | | | |

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| | 11:30 P.M. There was documentation on document titled " P.R.N. Medication tracking" for 2/5/11 at 10 P.M., 2/14 at 11:30 P.M. for Ativan.<br><br>For March 2011, all of the behavior sheets were blank as of 3/16/11.<br><br>The March M.A.R. indicated no P.R.N. Ativan had been given. However, the P.R.N. Medication tracking form indicated she received medication on 3/1/11 at 10 P.M. as well as 3/6/11 at 9 A.M. | | | |

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| F0514 SS=E | 2. In an interview during the initial orientation tour on 3/14/11 at 11:45 A.M., Director of Nursing #4 indicated Resident #33 expressed frequent somatic complaints, wanted her family "here all the time," and had been described by her family as having a long history of depression, anxiety, and "controlling' behaviors.<br><br>The clinical record for Resident #33 was reviewed on 3/15/11 at 1:45 P.M. Diagnoses included, but were not limited to, chronic pain, depression, and general anxiety disorder.<br><br>The March, 2011 physician order recap [recapitulation] form listed medications of: Xanax [an anti-anxiety mediation] 0.25 mg. [milligrams] one routinely at 1:00 P.M., Buspirone [Buspar--an anti-anxiety medication] 15 mg. routinely twice a day, and Lortab [Hydrocodone/APAP--a pain medication] 5/500 one routinely three times a day. In addition, the recap listed an order for Xanax 0.25 mg. one three times a day P.R.N. [as needed].<br><br>On 3/17/11 at 11:25 A.M., R.N. #6 provided a form titled "P.R.N. Medication Tracking." She indicated this form was used to document non-pharmacological | F0514 | Disclaimer: Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. 1. It is the policy of McGivney Health Care Center to provide each resident with a complete, accurate, accessible organized clinical record. All nurses were in-serviced on the facility's Behavior Documentation and new Policy and Procedure for Behavior Documentation to ensure the clinical records for residents # 2, #9, #14, and #33 would project consistent documentation, and ensure that all nonpharmocological interventions were utilized prior to P.R.N.s. 2. An audit was conducted on all other resident's receiving P.R.N.s for behaviors were reviewed by QA and individual adjustments made as appropriate. 3. Nursing in-service conducted on: Behavior Documentation The facility's new Policy and Procedure for Behavior Documentation 24hr Report Log Documentation All Staff in-service conducted on: Behavior Documentation 4. | 04/17/2011 |

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| | interventions attempted prior to administering a P.R.N. medication. She indicated a form titled "Behavior/Intervention Monthly Flow Record" was used to document behaviors specific to psychotropic medications that were prescribed for a resident.<br><br>Comparison of the "Controlled Substance Record" sign-out sheets for the P.R.N. Xanax, the M.A.R. [Medication Administration Record], and the "P.R.N. Medication Tracking" records for Resident #33 indicated the Xanax was inconsistently documented as follows:<br><br>December, 2010: 6 doses of the P.R.N. Xanax were documented as signed out on the "Controlled Substance Record." There were only 2 entries on the M.A.R.--both of which matched an entry on the "Controlled Substance Record." The "P.R.N. Tracking" record only listed 3 dates for attempting non-pharmacological interventions prior to administering the medication. One of those dates [12/7/10 at 11:30 P.M.] did not match a date on the "Controlled Substance Record," but did match an entry on the M.A.R.<br><br>January, 2011: 18 doses of the P.R.N. Xanax were documented as signed out on the "Controlled Substance Record." | | Charge nurses are responsible for consistently documenting all nonpharmocological interventions prior to using P.R.N.s. on the Behavior Monthly Flow Record, MAR and documenting any narratives on the Behavior Notes. All nurses will be responsible for documenting on the 24hr Report Log any utilization of P.R.N. psychoactive medications SSD/designee will be responsible for behavior audits each business day and bring findings to QA weekly. Nurses failing to adhere to the facility policies and procedures will be counseled by the DON up to and including disciplinary action. All other staff is required to document on the Behavior Monthly Flow Record and interventions they tried with resident and document any narratives on the Behavior Notes | |

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| | There were only six entries for administration on the M.A.R., and the dates for each of the 6 matched entries on the "Controlled Substance Record." There were 5 entries on the "P.R.N. Tracking" record, only 4 of which matched the "Controlled Substance Record," and the M.A.R.<br><br>February, 2011: 19 doses of the P.R.N. Xanax were documented as signed out on the "Controlled Substance Record." There were only 11 entries for administration on the M.A.R., and the dates for administration of each of the 11 matched entries on the "Controlled Substance Record." There were 8 entries on the "P.R.N. Tracking" record, only 7 of which matched both the "Controlled Substance Record" and the M.A.R.<br><br>March, 2011 [3/1 through 3/16/11]: 9 doses of the P.R.N. Xanax were documented as signed out on the "Controlled Substance Record." There was only 1 entry on the M.A.R., and that matched an entry on the "Controlled Substance Record." There were 6 entries on the "P.R.N. Tracking" record, all of which matched entries on the "Controlled Substance Record."<br><br>The "Behavior/Intervention Monthly Flow | | | |

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| | Record" form for the Xanax for December, 2010, January and February, 2011 listed targeted behaviors of "Depressed/Withdrawn," "Anxiousness," and "Increased Anxiety, i.e. Fidgeting, Wringing of Hands," respectively. The forms were blank for any documentation of behaviors.<br><br>The March, 2011 "Behavior/Intervention Monthly Flow Record" form for the Xanax listed a targeted behavior of "Anxiousness." Episodes were documented on the evening shift for 3/12, 13, 14, 15, and 16, and the night shift for 3/7 and 9/11.<br><br>In an interview on 3/16/11 at 10:45 A.M., the Administrator and R.N. #6 indicated they had become aware of a problem with the various documentation of behaviors, medications, and interventions. A weekly Behavior Committee meeting had been initiated.<br><br>In an interview on 3/17/11 at 9:20 A.M., the Director of Nursing #5 indicated any of the interventions listed on the "Behavior/Intervention Monthly Flow Record" could be used, and marked on the "P.R.N. Tracking" record. She indicated nursing administration had been working on getting this form completed, and had | | | |

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| | been doing a lot of teaching. | | | |

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| F0514 SS=E | 3. The clinical record of Resident #9 was reviewed on 3/17/11 at 9:10 A.M.<br><br>Diagnoses included, but were not limited to, Delirium, Depression, schizophrenia and dementia.<br><br>A nursing note, dated 12/28/10 at 8:00 P.M., indicated " Resident following male CNA (certified nursing assistant) around saying "I want you, I know you want me too." She followed him down the long hallway, tried to go into another resident's room where male CNA was assisting this resident (sic). She has been telling staff she is pregnant and naming two different male residents. When she is told by staff these comments are in-appropriate she yells at staff & then she gets mad and tries to fall on the floor."<br><br>A "Behavior/Intervention Monthly Flow Record", dated for the months of January 2011 through March 2011, indicated Resident #9 was being monitored for delusions, yelling and tearfulness. The behavior monitoring flow record indicated the following:<br><br>January 2011<br><br>Delusion of being pregnant - 1/2/11. This was not noted in the nursing notes. | F0514 | Disclaimer: Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. 1. It is the policy of McGivney Health Care Center to provide each resident with a complete, accurate, accessible organized clinical record. All nurses were in-serviced on the facility's Behavior Documentation and new Policy and Procedure for Behavior Documentation to ensure the clinical records for residents # 2, #9, #14, and #33 would project consistent documentation, and ensure that all nonpharmocological interventions were utilized prior to P.R.N.s. 2. An audit was conducted on all other resident's receiving P.R.N.s for behaviors were reviewed by QA and individual adjustments made as appropriate. 3. Nursing in-service conducted on: Behavior Documentation The facility's new Policy and Procedure for Behavior Documentation 24hr Report Log Documentation All Staff in-service conducted on: Behavior Documentation 4. | 04/17/2011 |

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| | Tearful - 0<br><br>Cursing - 1/21/11. This was not noted in the nursing notes.<br><br>February 2011<br><br>Delusion regarding a boyfriend - 3 times. Nursing notes indicated this behavior four times.<br><br>Yelling - 2/22/11. Nursing notes indicated this behavior 2/23/11.<br><br>Tearful - 2/24/11. Nursing notes did indicate the behavior of tearfulness 2/24/11.<br><br>March 2011<br><br>Delusion - 0<br><br>Yelling - 0. Nursing notes indicated this behavior two times.<br><br>Agitation - 0<br><br>Tearfulness - 0<br><br>4. The clinical record of Resident #14 was reviewed on 3/17/11 at 1:00 P.M. | | Charge nurses are responsible for consistently documenting all nonpharmocological interventions prior to using P.R.N.s. on the Behavior Monthly Flow Record, MAR and documenting any narratives on the Behavior Notes. All nurses will be responsible for documenting on the 24hr Report Log any utilization of P.R.N. psychoactive medications SSD/designee will be responsible for behavior audits each business day and bring findings to QA weekly. Nurses failing to adhere to the facility policies and procedures will be counseled by the DON up to and including disciplinary action. All other staff is required to document on the Behavior Monthly Flow Record and interventions they tried with resident and document any narratives on the Behavior Notes | |

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| | Diagnoses for Resident #14 included, but were not limited to, depression, dementia, anxiety and chronic obstructive pulmonary disease.<br><br>A "Behavior/Intervention Monthly Flow Record", dated for the months of January 2011 through March 2011, indicated Resident #14 was being monitored for combativeness and yelling/cursing. The behavior monitoring flow record indicated the following:<br><br>January 2011<br><br>Combative - January 9, 15, 19, 27 and 30, 2011. Nursing notes indicted Resident #14 was combative January 2, 15, 19, 27, 30 and 31, 2011.<br><br>Yelling - January 9, 16 and 30, 2011. Nursing notes indicated the Resident was yelling January 16 and 30, 2011.<br><br>February 2011<br><br>Combative - February 8 and 20, 2011. Nursing notes indicated the Resident was combative February 17 and 18, 2011.<br><br>March 2011<br><br>Combative - March 3, 7, 10 and 16, 2011. | | | |

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| | Nursing notes indicated the Resident was combative March 11, 2011.<br><br>3.1-50(a)(1)<br>3.1-50(a)(2) | | | |